

**SHERIFFDOM OF SOUTH STRATHCLYDE, DUMFRIES AND GALLOWAY
AT DUMFRIES**

[2016] FAI 18

B371/15

DETERMINATION

BY

SHERIFF BRIAN A MOHAN

UNDER THE FATAL ACCIDENTS AND SUDDEN DEATHS INQUIRIES (SCOTLAND)
ACT 1976

into the death of

ANDREW HAMILTON

Dumfries, 29 September 2016

The Sheriff, having heard evidence and having resumed consideration of the cause,
finds and determines in terms of the Fatal Accidents and Sudden Deaths Inquiry
(Scotland) Act 1976, Section 6(1) that:

[a] Where and when the death and any accident resulting in the death took place

Andrew Hamilton (dob 07/03/1987) ordinarily resided in West Lothian. On 3rd October 2014 he was a convicted prisoner in lawful custody at HMP Dumfries. He died on 3 October 2014 at 23.55 hours at Dumfries and Galloway Royal Infirmary, Bankend Road, Dumfries.

[b] The cause or causes of such death and any accident resulting in the death

The cause of the death of Andrew Hamilton was (1a) ischaemic heart disease due to (1b) coronary artery atheroma.

[c] The reasonable precautions if any whereby the death and any accident resulting in the death might have been avoided were

1. For nurses within the medical centre at HMP Dumfries to have completed an electrocardiogram (ECG) on Andrew Hamilton at around 5.30pm on 3 October 2014.
2. For the prison doctor to have advised nurses at HMP Dumfries at around 5.30pm on 3 October 2014 that further action should be taken by them if Mr Hamilton's presenting symptoms continued into the evening.
3. For nursing staff at HMP Dumfries to have called an ambulance for Andrew Hamilton at around 8pm on 3 October 2014.

[d] The defects, if any, in any system of working which contributed to the death or any accident resulting in the death

The electrocardiograph (ECG) machine within the medical centre at HMP Dumfries on 3 October 2014 was not functioning correctly. The machine had no paper to print the results of an electrocardiogram, and nursing staff had no access to replacement paper for it. Printing was necessary because the nurses were not trained to interpret the results of the ECG test and needed to fax the printed results to a doctor's surgery outside the prison.

[e] Any other facts which are relevant to the circumstances of the death

In terms of Section 6(1)(e) of the 1976 Act the Sheriff recommends:-

1. That a number of defibrillator machines are made available in HMP Dumfries for emergency use by prison staff when the prison medical centre is closed.
2. That Scottish Prison Service (SPS) install and maintain a system of individual cell emergency alarms which is effective at all times.
3. That consideration should be given by SPS to enabling a prison doctor to have appropriate access to relevant prisoner medical records when advice is being provided by the doctor in relation to a prisoner from a location other than the prison.

[1] Findings in Fact

Andrew Hamilton

1. Andrew Hamilton was born on 7 March 1987. From May 2010 to 6 December 2013 he was a prisoner serving a sentence and in lawful custody in Scotland. He was released on licence on 6 December 2013 and then recalled to prison on 29 April 2014. He was transferred to HMP Dumfries on or around 14 May 2014. He had served part of his sentence there prior to his recall. He remained a prisoner in lawful custody in HMP Dumfries continuously from 14 May 2014 until the date of his death. He died on 3 October 2014 when he was 27 years old.

Dumfries Prison

2. In October 2014 HMP Dumfries housed approximately 170 prisoners. The prison population was accommodated in cells located in one of five halls, identified by letters

A, B, C, D and E. Each hall was further divided into self-contained levels, denoted by a number. 'A' Hall had three levels; 'B' and 'C' Hall had four levels each.

3. On 3 October 2014 Andrew Hamilton's cell in HMP Dumfries was located in B Hall at level 2, identified as Hall B2. Hall B2 housed a maximum of 21 prisoners. Andrew Hamilton was in a double occupancy cell with prisoner JD. By 3 October the two prisoners had shared a cell for approximately one month.

Underlying medical conditions

4. Prior to the date of his death, Andrew Hamilton had not received any diagnosis of, or treatment for, cardiac problems. He had a diagnosed history of diabetes mellitus (known as diabetes). Diabetes mellitus is a major risk factor in the development of coronary artery atheroma.

5. Andrew Hamilton was a type 1 diabetic and administered his own insulin daily. He suffered from chronic heartburn for which he received daily medication known as Ranitidine. In addition he took anti-depressant medication and pain relief for recurrent shoulder pain. He received all of these medicines on prescription prior to his return to HMP Dumfries in May 2014. Some of his medication could only be taken in the prison's medical centre under the supervision of nursing staff.

6. Andrew Hamilton was regarded by the prison officers and medical staff who dealt with him on 3 October 2014 as a compliant prisoner who communicated well and did not cause difficulties in his management.

Medical Facilities at HMP Dumfries

7. In October 2014 HMP Dumfries had a medical centre with two consulting and treatment rooms. The centre was staffed by nurses whose dedicated place of work was the prison. They were employed by NHS Dumfries and Galloway. There were generally two nurses on duty at the prison daily from 7.15am until 9pm, with slightly reduced hours at weekends. Further medical cover was available from a doctor who conducted a morning surgery at the prison. Prisoners' medical records were kept electronically by Scottish Prison Service (SPS) on a software system known as VISION. The file referable to each prisoner highlighted personal details, relevant ongoing medical problems and medication prescribed. The file also detailed every medical consultation, examination or treatment of the prisoner during his time throughout the Scottish prison estate. The electronic file relating to Andrew Hamilton could be accessed in the prison medical centre.

8. Dr Ryaz Sabur was a general medical practitioner based in Dumfries. By October 2014 he had been a doctor for approximately 25 years and was the principal of a medical practice in the town. In addition to his GP surgery Dr Sabur had a contract with SPS to provide medical services to the prison population at HMP Dumfries. He had provided this service since 2000. He conducted surgeries onsite at the prison each weekday morning and some Saturdays for between one and two hours. Outwith those times he could be contacted by telephone for emergency duties and other advice.

5.30pm medical visit on 3 October 2014

9. Prison Officer James Duff was based in Hall B2 and knew most of the prisoners accommodated there, including Andrew Hamilton. Mr Duff was not aware that Andrew Hamilton had any particular health complaints. During the course of the afternoon of 3 October 2014 while within his cell area, Andrew Hamilton complained to Prison Officer Duff that he had chest pains. He had no other symptoms of pain or discomfort. Mr Hamilton had attended his work duties in the prison kitchens earlier that day. He declined the offer of medical attention. Shortly after 5pm Mr Duff spoke to Andrew Hamilton again. Mr Hamilton said he was still experiencing chest pain. Mr Duff told Andrew Hamilton to visit the prison medical centre. Prison Officer Duff contacted the medical centre staff and made arrangements for Andrew Hamilton to attend at that time and be seen by the nurses.

10. At around 5.30pm Andrew Hamilton was escorted to the medical centre and spoke with the two nurses on duty, Ms Lynsey Wood and Ms Emma McGowan. He told the nurses that he had central chest pain which had lasted for three to four hours. It was a “twisting or grabbing” type of pain with no radiation to his back or arms. He thought it was heartburn as this was a longstanding condition. He told the nurses that he had taken two Ranitidine - his prescribed heartburn pills - earlier in the day, but his heartburn had not eased.

11. The nurses tested Mr Hamilton’s pulse and blood pressure. The results were within normal parameters. The nurses also administered further heartburn medication, known as Gaviscon, in pill form. During this consultation with Mr Hamilton nurses Wood and McGowan decided to seek advice about Mr Hamilton’s presenting symptoms from the

prison doctor, Dr Sabur. At that time he was at his own medical practice outwith the prison. Dr Sabur and nurses Wood and McGowan knew each other. They had worked together earlier that day when Dr Sabur conducted his morning clinic. They had a good working relationship.

12. The nurses decided to conduct an electrocardiograph test, known as an electrocardiogram or ECG, prior to their contact with the doctor. An ECG measures heart rhythms and is designed to detect and identify irregular or unusual heart activity. When a patient is suffering chest pain, an ECG diagnoses whether the pain is cardiac in nature. The medical centre had an ECG machine which conducted such tests and issued a print out of its readings. Neither of the nurses was trained to interpret the results of the ECG test. They intended to send the printed results by fax to the prison doctor at his GP surgery, in order to inform their proposed discussion about Mr Hamilton.

13. Nurses Wood and McGowan were unable to perform the ECG. The machine was functioning, but had no paper from which the test results could be produced for onward transmission to the doctor by fax. The nurses could not access replacement paper for the ECG machine. It was in a locked stationery cupboard and the keyholder for the cupboard was not on duty that day.

Telephone Call to Prison Doctor

14. At around 5.40pm Nurse Lynsey Wood telephoned Dr Sabur at his surgery to discuss Andrew Hamilton's presentation. Emma McGowan was present in the medical centre with Ms Wood when this call was made. Mr Hamilton was in an adjoining room

at the time. Dr Sabur had seen Andrew Hamilton within HMP Dumfries in his capacity as the prison doctor on a few occasions. Mr Hamilton had served part of his sentence in Dumfries prior to his release in December 2013. Dr Sabur met with Mr Hamilton on 14 May 2014 at the time of his transfer to HMP Dumfries following his recall. Dr Sabur had further consultations with Mr Hamilton on 11 June and 9 July 2014 when the presenting complaint related to Mr Hamilton's shoulder.

15. Nurse Wood had Andrew Hamilton's medical record on the VISION system displayed onscreen before her while she made the call to Dr Sabur on 3 October. She told the doctor about Mr Hamilton's symptoms that day, his chronic heartburn, and the medication he had taken for that. She said that she and her colleague had provided additional heartburn medication. She told the doctor that she had intended to perform an ECG but the machine was not functioning. At the time of the call Dr Sabur had no access to Andrew Hamilton's records on the VISION system. Dr Sabur advised the nurses to monitor Mr Hamilton. He said that he could see him at the following morning's clinic. Details of this consultation were noted on the VISION file by Lynsey Wood. Mr Hamilton was then returned to his cell.

8.00pm medical visit on 3 October

16. Shortly before 8pm on 3 October 2014, as nurses Wood and McGowan were coming to the end of their shift, Lynsey Wood noted that Andrew Hamilton had not returned for his prescribed night medication, which was to be taken in the presence of the prison medical staff. Such a refusal to attend for his prescription medication was not unusual.

Nurse Wood wanted to check how Mr Hamilton was progressing after the consultation earlier that evening. She therefore arranged for him to be sent back to the medical centre.

17. Mr Hamilton attended at the medical centre; he walked there unaided. He told the two nurses that he was still suffering from chest pain. The pain eased when he sat upright. He complained also of a throbbing pain in his shoulder, and was noted to have a crackly cough. He appeared brighter than at the time of his earlier visit and was in good spirits. His blood pressure was taken again and remained within normal range. The nurses formed the view that his symptoms were improving. At the conclusion of the consultation around 8pm the nurses told Mr Hamilton that if he felt unwell during the night he should let someone know. He was returned to his cell for the night.

Cell emergency call system

18. At 9pm each night prisoners were confined to their own cells until the following morning. The period at night after 9pm was known as 'lockdown'. After 9pm there were fewer prison officers on duty than during the day. Prison officers on night shift were allocated to one of two sections: one section comprised Halls A, B and C, the other was made up of the remaining Halls, D and E.

19. Within each cell in Dumfries Prison in October 2014 there was a button for occupants of the cell to call for emergency assistance. This was the only means by which help could be summoned when prisoners were locked in their cells overnight. The system was designed to alert prison staff to a request for emergency help. When an emergency button was activated it gave off a short 'buzz' sound and illuminated a light positioned

outside the cell door. The sound was audible and the light was visible within the specific hall on which the cell was located.

20. On 3 October 2014 the prison staff covering night shift on the section containing Halls A, B and C were based at an observation suite in Hall A1. In the observation suite at A1 there was a central panel which indicated when an emergency button had been pressed within any cell in A Hall.

21. Activation of an emergency cell button in B Hall also illuminated a light on a central panel located within B Hall. This panel identified the individual cell within which the button had been pressed. An emergency button pressed from a cell in B Hall did not illuminate the panel in the observation suite on A1. The area housing the central illuminating panel in B Hall was not continuously staffed at night. It was observed only when prison officers carried out night patrols of the halls.

22. To conduct a night patrol a single officer walked a route which took him or her to each level of Halls A, B and C to check for anything untoward, such as an emergency call. A patrol was conducted every 30 minutes; as the inspection of each level was completed the officer's check was recorded electronically on a system known as "pegging". Completion of the patrol took around 5 minutes. Between these 'pegged' inspections prison officers sometimes conducted more informal checks on the status of B Hall by walking from the observation suite at A1 a short distance into B1.

Emergency call from cell on 3 October 2014

23. Andrew Hamilton returned to his cell after the 8pm visit to the medical centre. JD returned to the cell just before 9pm. He observed that Mr Hamilton was subdued and was watching television while sitting upright in a chair. JD sat on his bunk bed and also watched the television. Around 10pm Andrew Hamilton went into the lower bunk while JD remained on bed above. Shortly before 11pm JD was alerted to Mr Hamilton banging on his bed from below and groaning in pain. JD spoke to Mr Hamilton and concluded that he was in severe distress. His breathing was shallow and he was unable to speak. JD decided to press the emergency cell button to seek assistance. He pressed the button shortly after 11pm.

24. At or around 11pm Prison Officer Stephen Helsegrave began a patrol of B Hall. At 11.02pm he saw a light illuminate on the central board. The board indicated that an emergency call had come from a cell in Hall B2. He immediately went to the cell, which was occupied by Andrew Hamilton and JD. He viewed the inside of the cell from the inspection hatch in its door. JD told him that Andrew Hamilton was having severe difficulties. Mr Hamilton was lying on a bottom bunkbed. Following the explanation provided by JD, Officer Helsegrave noticed that Mr Hamilton's breathing was shallow and that he was quiet. JD was unable to elicit any response from Mr Hamilton at that point.

25. Following his conversation with JD Mr Helsegrave alerted colleagues to the emergency by telephoning his supervisor at the gatehouse. Prison protocol required a team of three to be present before a cell could be opened. Mr Helsegrave alerted

colleagues using a 'Code Blue'. This was a shorthand indication that a prisoner had breathing difficulties.

26. Prison Officer Peter Mutch was on duty in the prison gatehouse. He responded to the emergency call from Mr Helsegrave and arrived at the cell at approximately 11.04pm accompanied by Officer Katrina Glendinning.

27. Peter Mutch immediately opened the cell. He observed that Mr Hamilton was in difficulty. He radioed the prison control room to summon an ambulance. He then decided to perform emergency chest compressions to try and revive Mr Hamilton.

Prison Officer Glendinning took JD to an adjoining cell and placed him safely there. She then returned to assist her colleague Peter Mutch. Prison Officer Helsegrave went to the front gate of the prison to await the arrival of the ambulance.

28. At around 11.20pm, paramedics arrived at the prison in an ambulance. Mr Helsegrave met them at the prison entrance and immediately escorted them to Mr Hamilton's cell in Hall B2. The paramedics began treating Mr Hamilton with a defibrillator which they had brought. Mr Helsegrave returned to the gatehouse to await the arrival of a second ambulance.

29. Peter Mutch continued to perform CPR in the form of chest compressions continuously from around 11.05pm until the paramedics reached the cell at around 11.22pm. Mr Hamilton was unresponsive to the treatment administered during the chest compressions performed by Peter Mutch. He remained unresponsive during the treatment provided by the paramedics, which included treatment by means of their defibrillator machine. Andrew Hamilton was removed by ambulance staff to Dumfries

and Galloway Royal Infirmary (DGRI). He was pronounced dead by a doctor there at 11.55pm.

Death and post mortem results

30. The cause of Andrew Hamilton's death was ischaemic heart disease due to coronary artery atheroma. At post-mortem pathologists found evidence of heart disease comprising severe narrowing of the three major coronary vessels, one with superimposed thrombus, pre-existing fibrosis in the posterior wall of the left ventricle indicative of infarction in the past and changes indicative of acute infarction, commonly referred to as heart attack, of around 12 – 24 hours in duration. Andrew Hamilton's heart disease was undiagnosed before his death.

31. Analysis of samples collected at post-mortem detected therapeutic concentrations within the deceased of amitriptyline (an anti-depressant), paracetamol, quetiapine (an antipsychotic) and a low concentration of alcohol which could have been the result of post-mortem production of ethanol in urine.

Prison officer emergency training

32. As at 3 October 2014, all operational staff in HMP Dumfries had received emergency aid training. Prison officers Stephen Helsegrave, Katrina Glendinning and Peter Mutch, the three officers who attended at Andrew Hamilton's cell shortly after 11pm on 3 October 2014, had all received appropriate emergency training. On 3 October 2014 a mobile defibrillator machine was available for use by prison staff in HMP Dumfries

when no medical staff were on shift. The defibrillator was located in the prison gatehouse.

NOTE:

Representation

[2] Representation at this Inquiry was as follows:-

1. For the Crown: Ms Carrie Macfarlane, Procurator Fiscal Depute
2. For Scottish Prison Service: Mr Michael Higgins, Solicitor
3. For Prison Officers Association Scotland: Mr Graham Gibson, Solicitor
4. For NHS Dumfries and Galloway: Ms Helen Watts, Advocate
5. For Dr Ryaz Sabur: Mr James Stewart, Solicitor

Evidence led

[3] Evidence in this Inquiry was led on 18, 19, 20, 21 and 22 April 2016. There were two joint minutes in which certain evidence and productions were agreed. Written submissions were provided after the conclusion of evidence, and these were supplemented by oral submissions on 3 June 2016. The following witnesses were called to give evidence to the Inquiry:

1. Mrs Lynn Hamilton, deceased's mother
2. JD, prisoner at HMP Dumfries
3. JC, prisoner at HMP Dumfries
4. James Duff, prison officer, Dumfries
5. Kerry Payne, prison officer manager, Dumfries
6. Emma McGowan, nurse, HMP Dumfries
7. Lynsey Wood, nurse, HMP Dumfries
8. Dr Ryaz Sabur, general practitioner and prison doctor
9. Stephen Helsegrave, prison officer, Dumfries
10. Peter Mutch, prison officer, Dumfries
11. Alison MacDonald, Head of Service and Chief Nurse, East Lothian NHS
12. Louis Stankovic, paramedic

- 13. Dr Norman Wallace, retired GP and medicolegal advisor
- 14. Dr Stuart Hutcheon, consultant cardiologist.

Purpose of Inquiry

[4] A Fatal Accident Inquiry (FAI) has to determine the place and cause of death of the individual concerned. In terms of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 its function is also to do the following:

- under Section 6(1)(c) of the Act to identify any “reasonable precautions whereby the death might have been avoided”;
- under Section 6(1)(d) to identify “the defects, if any, in any system of working which contributed to the death...”; and
- under Section 6(1)(e) to identify “any other facts which are relevant to the circumstances of the death”.

[5] Any Inquiry therefore has as its purpose to find facts and not fault. The Inquiry carries out an important function as it allows the family of the deceased to hear in public the precise circumstances of the death of their relative. The purpose is also to allow lessons to be learned for future practice, where appropriate.

The scope of Section 6(1)(c) in a medical FAI

[6] It is appropriate for me to comment further on both the scope and the perspective of this FAI, particularly so far as it relates to decisions made by those who dealt with Mr Hamilton on the day of his death. This is relevant because the evidence at this Inquiry focused, in substantial part, on medical matters and, in particular, on decisions taken by the nurses and doctor who served the prison. The Inquiry was

complicated by a divergence of evidence about information exchanged between the prison nurses and doctor regarding Andrew Hamilton's underlying condition in the hours before his death. This had a bearing on the treatment decisions taken. A number of submissions were made about the approach to be taken in relation to the analysis of such decisions.

[7] It is well established that an Inquiry of this nature does not determine any question of civil or criminal fault or liability. In the case of *Black v Scott Lithgow Ltd* 1990 SLT 612 Lord President Hope stated at page 615:

"The function of a sheriff at a Fatal Accident Inquiry is different from that which he is required to perform at a proof in a civil action to recover damages. His examination and analysis of the evidence is conducted with a view only to setting out in his determination the circumstances to which the sub section refers, insofar as this can be done to his satisfaction. He has before him no record or other written pleading, there is no claim of damages by anyone and there are no grounds of fault upon which his decision is required".

[8] Ms Watts, representing NHS Dumfries and Galloway, was concerned at the implicit criticism which she perceived would apply to the prison nurses if any finding were made that other precautions might have been taken by them. In her submissions she drew my attention to a particular approach which she contended should apply when, as here, decisions by medical professionals were under scrutiny. Ms Watts cited the findings by Sheriff Baird in Glasgow following the death of Marion Bellfield (Determination 28th April 2011) in which he stated:

"I agree that when one has a situation which solely involves the exercise of clinical judgment, where a range of reasonable actions might be taken, and the choice as to which to take rests on the skill and experience of a doctor based upon such information as is available to him at the time, and the doctor happens to choose a course which results in death, it would be wrong to hold that the

selection of another option within the range, which might have prevented the death, was a reasonable precaution which ought to have been taken. Not only does that involve straining the meaning of precaution, but such a finding would be of no real practical benefit to others in the future. A Fatal Accident Inquiry cannot prescribe how doctors or nurses should exercise their judgment”.

[9] Ms Macfarlane for the Crown, however, cited the observation made by Sheriff

Reith in Glasgow in the Inquiry into the death of Charmaine Weir (23rd January 2003):

“A Sheriff is required to proceed on the basis of the evidence adduced without regard to any question of the state of knowledge at the time of the death. The statutory provisions are concerned with the existence of reasonable precautions at the time of death and are not concerned with where they could or should have been recognised. They do not relate to the question of foreseeability or risk at the time of death...the statutory provisions are widely drawn and are intended to permit retrospective consideration of the matters with the benefits of hindsight and on the basis of the information and evidence available at the time of the inquiry”.

[10] The question of whether the death “might have been avoided” by a reasonable precaution is a matter which has been the subject of some consideration in a number of other inquiries. In his submissions before the Inquiry Mr Stewart, acting on behalf of Dr Sabur, cited a passage in *Sudden Deaths and Fatal Accident Inquiries* by Ian H B

Carmichael (3rd edition 2005), where the author notes at p.174 that:

“...the precise wording of Section 6(1) (c) must be kept in mind. What is required is not a finding as to a reasonable precaution whereby the death “would” have been avoided but where by the death “might” have been avoided. Certainty that the accident or the death would have been avoided by the reasonable precaution is not what is required. What is envisaged is not a “probability” but “a real or lively possibility that the death might have been avoided by the reasonable precaution”.

[11] This description of a “lively possibility” itself comes from a finding by Sheriff Kearney in Glasgow (Determination into the death of James McAlpine) on 17 January 1986, which source is noted by Carmichael.

[12] These observations by other sheriffs conducting FAIs were of assistance. It appears clear from a number of Determinations that the inquiry has to use the benefit of hindsight. A review of Fatal Accident Inquiry legislation instigated by The Scottish Government and conducted by Lord Cullen endorsed this approach. In his *Report of the Review of Fatal Accident Inquiry Legislation* (2009) Lord Cullen noted as follows:

“8.12 ...there is a division of view as to whether “might have been avoided” does or does not include a consideration of hindsight. I would comment that, having regard to the public interest in the learning of lessons from the circumstances of a fatality, there is considerable force in the view that sheriffs should take hindsight into account”.

[13] The focus of a Fatal Accident Inquiry, then, is hindsight after the event, not foreseeability before it. Accordingly, any “reasonable precaution” has to be assessed from that vantage point. However, the finding by a sheriff of a reasonable precaution by which the death might have been avoided does not necessarily mean that there was any fault in that precaution not having been taken. In the Rose Park Inquiry Determination (20 April 2011) Sheriff Principal Lockhart stated:

“The question of reasonableness is directed to the precaution which is identified. The issue is not whether an individual or an organisation behaved in a reasonable or unreasonable way, but whether or not there is a precaution which is a reasonable one and which might have made a difference”.

[14] From analysis of these earlier decisions it would appear, therefore, that evidence of a decision made by a doctor or nurse, even where that is found to be a reasonable one, does not preclude a sheriff from finding that another reasonable precaution might have prevented the death. That, surely, is the way in which any necessary lessons can be learned.

[15] It is relevant to note, for the purposes of this Inquiry, therefore, that:

- 1) findings should be made with the benefit of hindsight,
- 2) there has to be some standard, established by evidence, before a precaution is regarded as a reasonable one which might have prevented the death, the standard being one of a “lively possibility”,
- 3) caution should be exercised by a sheriff in a medical FAI before venturing into the area of reasonable clinical judgements exercised by medical professionals, but
- 4) as the FAI procedure is not a fault-finding exercise, a finding of a reasonable precaution which might have prevented the death does not mean that a different decision taken was itself not reasonable.

Reasons for findings

[16] At the beginning of this Determination I set out a number of findings under Section 6 of the Act, under the headings of “reasonable precautions”, “defects in systems”, and “other relevant circumstances” which have resulted in a number of recommendations. Having already set out above the facts which I found established, I now turn to a more detailed explanation of my Section 6 findings, the reasons for these, and the evidence before the Inquiry on which the findings were based. The Inquiry heard that a number of changes have been made within HMP Dumfries since Andrew Hamilton’s death; I will draw attention to these where appropriate.

Section 6(1)(c): “reasonable precautions”

1. For nurses within the medical centre at HMP Dumfries to have completed an electrocardiogram (ECG) on Andrew Hamilton at around 5.30pm on 3 October 2014.

[17] The evidence in respect of this visit to the medical facility was quite straightforward. Mr Hamilton, a long time sufferer of heartburn, received medication known as Ranitidine. He usually took his medication, although did not always do so. At around 5.30pm on 3 October, at the suggestion of Mr Duff, prison officer, Mr Hamilton presented himself at the medical centre. Nurses McGowan and Wood saw him there. He explained his symptoms, namely that he had heartburn which had persisted for three or four hours since earlier in the afternoon, that he had taken his usual medication but that it had not eased. He appeared in reasonable spirits with the nurses although was in some discomfort. The nurses gave him the only heartburn medication which they were authorised to provide (Gaviscon). They decided also that an ECG would be a useful test to carry out. The machine was available but had no paper. The stationery cupboard was locked and the person who had the key to the cupboard was on holiday, leaving the nurses with no access to paper for the machine.

[18] Dr Stuart Hutcheon, consultant cardiologist at Ninewells Hospital in Dundee, explained the purpose of an ECG machine. It is designed to identify irregular rhythms in a person's heart and to establish if chest pain is heart related. A '12 lead ECG' (the type of machine which the prison had) was described by Mr McCutcheon as "the gold standard test". He said in 90% of cases the ECG gave an accurate diagnosis. Nurses Wood and McGowan did not explicitly state that they feared any heart problems on the part of Mr Hamilton. He displayed none of the 'classic' signs of a person susceptible to heart problems; he was 27 years of age, was not overweight and had no reported history of heart difficulty. However, they considered the ECG as a precaution. Since the prison

doctor, Dr Sabur, had finished his clinic for the day and was off site at his own GP surgery, the nurses thought that it would be useful to speak to him with the benefit of the ECG findings, in case he asked for them.

[19] While neither was trained to read the findings of an ECG they anticipated that they could fax Dr Sabur the readings from the machine. They thought this would provide him with further relevant information when they sought his advice. It is clear that the nurses were unable to carry out the procedure because the machine had no paper. Given the judgement which they exercised, namely that they wished to carry out the ECG procedure, and given the evidence from Dr Hutcheon about the specialised information which the machine could provide, I consider that it was a reasonable precaution for an ECG test to have been carried out at the 5.30pm visit.

2. For the prison doctor to have advised nurses at HMP Dumfries at around 5.30pm on 3 October 2014 that further action should be taken by them if Mr Hamilton's presenting symptoms continued into the evening.

[20] Dr Sabur's routine involved him providing medical services to the prison five or six days a week. His surgery ordinarily took place for up to two hours in the mornings. He then returned to his own general practice in Dumfries but was available by telephone to be called back out to the prison or to provide information or advice when necessary. He had visited the prison during the morning of 3 October and completed his clinic. He knew nurses Wood and McGowan and had worked with them earlier that day. All appeared to have a good working relationship, based on mutual trust. The nurses wanted a conversation with Dr Sabur at their 5.30pm meeting with Mr Hamilton.

They were seeking reassurance from him about Mr Hamilton's situation. They were not particularly concerned by Mr Hamilton's presentation or his history but they considered that it was a wise move to consult the doctor.

[21] The nurses did not recollect specifically telling Dr Sabur about the diabetes.

Neither of them was aware that diabetes could be a risk factor for heart problems. They were, however, sure that Dr Sabur, who had already met Mr Hamilton, also knew of his diabetes when they sought his advice.

[22] The nurses were in front of a computer screen which displayed Mr Hamilton's VISION file at the time the call was made. His diabetes was highlighted at the top under 'Patient Summary' (a copy of the file was provided in evidence at the Inquiry). Nurse Wood, who spoke to Dr Sabur, said that she "*would have*" told Dr Sabur about Mr Hamilton's diabetes during the telephone call. The most that Nurse McGowan (who was present but not a party to the call) could say was that if Nurse Wood omitted to provide that information she would have reminded her colleague to mention it. Neither said in evidence that they did tell (or in Ms McGowan's case heard her colleague tell) Dr Sabur of the diabetes. The statements they each provided to Police Scotland the following day were silent on the point.

[23] Dr Sabur's evidence on the matter was that he received a call from the prison nurses after 5.30pm and was quite prepared to offer advice about the unexpected visit they had from Mr Hamilton. Receiving calls from the prison was normal; he could receive two or three calls per week or go for periods with no enquiries outside his prison clinics. He was satisfied that the nurses had dealt appropriately with someone

complaining of chronic heartburn. He was clear in evidence that he had no notes in front of him, had no recollection of the particular patient, and was not told of the diabetes. He did not take any notes of the call; the practice was that notes were listed on VISION by the person making the call from the prison. No police statement by Dr Sabur was provided at the Inquiry.

[24] Dr Sabur had met Mr Hamilton on a number of occasions and treated him for a shoulder complaint within the prison. But his last meeting with the prisoner was three months before, in July 2014. He was aware that diabetes was a risk factor for heart problems. Chronic diabetes affected the nervous system; as a result a patient may not be aware of his own symptoms. If he had known or been told of the patient's diabetes on 3 October, he would recognised the possibility that the reported heartburn was cardiac related, and would have visited the prison to see Mr Hamilton that evening.

[25] Dr Sabur said that he enquired whether there was any other reported cause of the chest pain, such as exercise. He knew that no ECG could be performed as there was no paper for the machine. His advice was to give the patient something for heartburn and then "*see what happens*". He said that he "*took it for granted*" that if the patient did not improve, the nurses would get back in touch with him. If necessary he would see the patient the following morning at his clinic.

[26] It will be apparent from the above that there was conflicting evidence at the Inquiry about the conversation which took place between the nurses and Dr Sabur. Much evidence at the Inquiry focused on the question of Mr Hamilton's diabetes and whether Dr Sabur knew of or was told of this background during the telephone call on 3

October. It was apparent that the question of whether Dr Sabur had been told of Mr Hamilton's diabetes at the time of the telephone call was the source of much anxiety. Both nurses were recalled to give further evidence on the point after Dr Sabur's evidence had been completed. At the conclusion of the hearing I was invited by Ms Watts to accept that the nurses were credible and reliable and that, on the balance of probabilities, I should find that they had informed Dr Sabur of the patient's diabetes. Mr Stewart, acting for Dr Sabur, urged me not to make such a finding in light of the evidence heard from all the witnesses about their actual recollections of the call.

[27] The evidence on the point was therefore divided. I should point out that evidence was also divided on the less significant question of the Gaviscon given to Mr Hamilton. Dr Sabur's evidence was that he advised that the nurses should provide the heartburn pills (in addition to the prescribed medicine) whereas the nurses' evidence implied that they had made the decision. While that is not crucial to the circumstances of Mr Hamilton's death, I considered that this gave an indication of the informal nature of the discussions between the doctor and the nurses.

[28] Ultimately I was not persuaded on the balance of probabilities to make a finding either that the doctor was or was not aware of the diabetes during the telephone call on 3 October 2014. I should point out that while the issue was understandably treated by parties at the Inquiry as significant, it did not have a direct bearing on my conclusions as to reasonable precautions. It did, however, have a bearing on my recommendation about the doctor having access to the VISION file when giving advice offsite, a point on which I will provide further detail later.

[29] Dr Norman Wallace is a retired general practitioner who gave evidence before the Inquiry about the responsibilities and expectations of general medical practice. He was engaged as a 'Trainer' in general practice for many years and worked as a police casualty surgeon. He had given evidence previously to fatal accident inquiries. He prepared a Report dated 1 March 2016 in advance of giving evidence before the Inquiry. His report and evidence made reference to a resource called 'Patient.co.uk'. He had appended two articles on chest pain from there and described their contents as *"the level of knowledge that I would expect an ordinarily competent general practitioner to have."*

[30] Dr Wallace noted that chest pain is a *"very common presentation"*. He said that a GP usually has a *"wider perspective"* than nurses. From his analysis of the background and records he noted a number of elements which were pertinent to the telephone discussion at 5.30pm. These were:

- 1) the chest pain had persisted for some hours,
- 2) it had not responded to the usual medication (Ranitidine) which may have suggested that it was not heartburn,
- 3) the nurses had considered it appropriate to carry out an ECG. On this point he said in evidence *"I wouldn't normally do an ECG on a young man with heartburn. There was something that made them suspicious."*
- 4) The ECG could not be completed,
- 5) There was a lack of clarity about any relevant family history.

[31] These were factors which suggested a need for *"safety netting"*, or guidance about further action to be taken. Dr Wallace concluded that the nurses should have been advised that, if the symptoms persisted, the doctor should be contacted again or the patient sent to hospital.

[32] Following the 5.30pm telephone call Nurse Lynsey Wood recorded details on VISION. She typed the following entry on Mr Hamilton's file at the time:-

"Spoke with MO [medical officer] and he states he is happy for him to be monitored and will review in am if necessary".

[33] This accorded with Dr Sabur's evidence, noted above, about providing heartburn medication after which he wanted the nurses to *"see what happens"*. Taken together with the doctor's evidence that he *"took it for granted"* that the nurses would contact him later if required, this reinforces my conclusion that there was an ease in the interaction between the doctor and the nurses. Dr Sabur was satisfied that the experienced prison nurses had taken appropriate steps to deal with Mr Hamilton's reported symptoms, and assumed that he would be contacted later if necessary. The difficulty, however, is that the nurses were evidently seeking guidance from the doctor, and there was a lack of clarity in the direct advice to the nurses about what they should do next.

[34] Notwithstanding the competing recollections about whether or not the doctor was aware of Mr Hamilton's diabetes, I have concluded that a reasonable precaution would have been for Dr Sabur to provide clearer advice to the nurses about Mr Hamilton's ongoing care that evening. Specifically, I have concluded that a reasonable precaution would have been for Dr Sabur to have advised the nurses that further action should be taken by them if Mr Hamilton's symptoms continued. This finding is based on the observations made by Dr Wallace. The evidence before the Inquiry was that, if Mr Hamilton had been sent to hospital at 8pm, it is likely he would have survived.

3. For nursing staff at HMP Dumfries to have called emergency services for Andrew Hamilton at around 8pm on 3 October 2014.

[35] Despite the advice noted by Nurse Lynsey Wood in the VISION system following her conversation with Dr Sabur, a question arose about what would have been a reasonable precaution during the nurses' second consultation with Andrew Hamilton at around 8pm. It was Nurse Wood who insisted that Mr Hamilton should come back. He made his own way to the medical centre. He stated that his symptoms eased when he sat upright and he looked brighter. However, by that stage his heartburn had persisted for about five or six hours. He was still in pain. He had received two forms of heartburn medication (Ranitidine and Gaviscon) which had not alleviated his chest pain.

[36] Ms Alison MacDonald gave evidence before the Inquiry as an expert in nursing. She was Chief Nurse for East Lothian Health and Social Care Partnership. Her roles included responsibility for healthcare teams within HMP Edinburgh and HMP Addiewell. She prepared a Report on 12 October 2015 in advance of her appearance before the Inquiry. Ms MacDonald offered the view that it would have been appropriate for the nurses in HMP Dumfries to have 'escalated' Mr Hamilton's care at the 8pm consultation. In all probability this would have involved arranging his transfer to Accident and Emergency for assessment. Ms MacDonald reached this conclusion because of the persisting symptoms which Mr Hamilton was experiencing, the duration of the pain (five or six hours at that point), the medication which had not succeeded in resolving the pain, the crackly cough which was then noted, and the uncertainty arising out of the failed ECG which the nurses had wanted to carry out earlier.

[37] It was submitted on behalf of the nurses at the Inquiry that it would not have been a reasonable precaution to expect that they should have escalated the patient's care, as this would have involved their overriding the doctor's earlier advice to 'monitor' Mr Hamilton. I have some sympathy with their position. However, a reasonable precaution is a reasonable precaution. Notwithstanding the nurses' own view of their conversation with Dr Sabur, in effect their decision at 8pm was to do nothing further, despite the persisting symptoms. I accepted the evidence of Ms MacDonald as a nursing expert that an escalation in care by calling emergency services would have been a reasonable precaution.

Section 6(1)(d): defect in system of working

The electrocardiograph (ECG) machine within the medical centre at HMP Dumfries on 3 October 2014 was not functioning correctly. The machine had no paper to print the results of an electrocardiogram, and nursing staff had no access to replacement paper for it. Printing was necessary because the nurses were not trained to interpret the results of the ECG test and needed to fax the printed results to a doctor's surgery outside the prison.

[38] A finding under 6(1)(d) is of a different nature to a finding under 6(1)(c). Section 6(1)(c) involves a reasonable precaution which might have prevented the death. A finding under 6(1)(d) involves a defect in a system of working which is found to have contributed to the death. My only finding in this regard relates to the ECG machine. The ECG machine had been obtained by SPS as an item of equipment to assist medical staff treating prisoners within HMP Dumfries. Nurses Wood and McGowan knew how to use the machine although they did not know how to interpret its results. On meeting Mr Hamilton at the 5.30pm consultation on 3 October 2014, they concluded that an ECG

reading faxed to Dr Sabur would provide useful information for his decision about what to do with a prisoner suffering from persistent heartburn. They were thwarted in that plan by the machine having no paper and the breakdown in the system which would have allowed replacement paper. The one key holder for the locked stationery cupboard was on holiday so no replacement paper could be accessed. The services of that machine and the information it provided were therefore denied to all of the medical staff who treated Mr Hamilton that evening.

[39] The nurses became aware at 5.30pm that they could not use the ECG machine. The problem remained at 8pm when they saw Mr Hamilton again. Dr Hutcheon, the consultant cardiologist, gave evidence about the potential value of the ECG in diagnosing Mr Hamilton's heart condition. As a matter of fact Mr Hamilton was having a heart attack at the time of the consultations at the medical centre. This was, of course, unknown by anyone at the time but was part of the findings at post mortem. Dr Hutcheon said that an electrocardiogram would have been likely to show up the heart rhythm abnormalities "*at some point*". While he could not be certain that a 5.30pm reading would have shown this, he said that by 7.30pm or later it was "*very likely*" that readings would have been abnormal. He went on to say that, had Andrew Hamilton's condition been assessed with appropriate equipment "*it was very likely he would have survived this event*".

[40] Dr Hutcheon's Report, prepared in advance of the Inquiry and spoken to by him in his evidence, was even more direct. In his Report, dated 18 August 2015 he wrote the following (at p.2):

"I think it is extremely likely that if Mr Hamilton had undergone an ECG this could have prevented his death. He(sic) symptoms were present for most of the afternoon and evening culminating in an anterior myocardial infarction and if an ECG were to be performed at 5.15pm or 7.30pm it is very likely this would have shown ST segment changes consistent with myocardial ischaemia or infarction."

[41] I have therefore concluded that the breakdown in the functioning of the ECG machine represented a defect in a system of working which contributed to Mr Hamilton's death. It appears likely that, had relevant information been provided from an ECG machine printout shortly after 5.30pm, Mr Hamilton's care would have been escalated to a point where he would have survived.

6(1)(e): other circumstances relevant to the death

[42] Under this heading I have made three recommendations. The death of Andrew Hamilton occurred in circumstances where there were a number of factors which collided to result in him not receiving treatment which would have recognised his undiagnosed heart disease. The recommendations I have made do not come under the category of reasonable precautions or defects in a system of working, for reasons which I will explain in relation to each of them. Nevertheless each of these factors is a relevant circumstance from which important lessons can be learned.

1. That Scottish Prison Service (SPS) install and maintain a system of individual cell emergency alarms which is effective at all times.

[43] The evidence about the emergency call system which applied to B Hall in HMP Dumfries in October 2014 was disturbing. Logically, the prison had fewer staff on duty

during the hours at night when prisoners were confined to their locked cells. The halls within the prison were grouped together. Halls A, B and C were one grouping. On 3 October, the member of prison staff on duty within Halls A, B and C was based at an observation suite located in A Hall. This observation suite, as its name suggests, contained, among other items, a panel which identified the appropriate cell when a prisoner pressed an emergency button. But the illuminated panel within the observation suite supposedly serving halls A, B and C only alerted prison staff to emergency buttons pressed in A Hall.

[44] When an emergency call button was pressed in B Hall it illuminated a light outside the door of the cell and on a panel. But the call did not immediately alert any prison staff. The only way such a call for emergency assistance could be detected was either when the prison officer conducted the patrols every 30 minutes, or when officers, on a more informal basis, "*popped through*" from the observation suite in A Hall to B Hall to see if any lights were showing. An activated cell alarm could be heard within B Hall but was not audible to officers located within A Hall's observation suite.

[45] I found on the facts of this case that the button was pressed by JD while prison officer Helsegrave was doing his 11pm patrol of B Hall. The officer, therefore, was able to respond immediately. JD said in his evidence that he believed he had waited a long time for a response. This contrasted with his police statement where he said that help came "*a short time*" after he pressed the 'buzzer'. Officer Helsegrave's evidence was that he heard the buzzer being activated while he was within B Hall and responded immediately. I accepted his evidence on this point. While JD was a helpful witness, Dr

Hutcheon said in part of his own evidence that members of the public or onlookers who observe the traumatic event of a heart attack happening in front of them often have a distorted view of the time it takes for help to come. In his experience, the perception of such onlookers was often that help took a long time to arrive, when in fact it had only taken a few minutes.

[46] However, the evidence about the system still led to an unsatisfactory conclusion. A call for help in urgent circumstances in B Hall would be certain to alert prison officers to the emergency for only 5 minutes out of every 30. To put it another way, this system worked for only 10 minutes each hour. For up to 50 minutes an hour the system of emergency call buttons in B Hall was not likely to activate an emergency response until the next hall patrol began, which could be up to 25 minutes later. Outwith the patrol times, the system relied on the occasional informal check made by a prison officer. Since such further checks were unregulated, unmonitored and not part of the 'pegged' patrols, it was impossible to conclude how often this practice was carried out.

[47] It is against that background that I consider it appropriate to recommend a more robust and effective cell alarm system to alert prison staff immediately to a call for emergency help when one is made. Evidence was given at the Inquiry that the system has been amended since October 2014. The Inquiry was informed that HMP Dumfries now has an observation panel which enables emergency calls from every cell to come to the attention of prison staff immediately.

2. That a number of defibrillator machines are made available in HMP Dumfries for emergency use by prison staff when the prison medical centre is closed.

[48] In October 2014 HMP Dumfries had a mobile defibrillator. It was located within the gatehouse. Prison Officer Mutch was in the gatehouse when he was summoned to B Hall shortly after 11pm. He did not take the defibrillator machine with him to the emergency call. Three officers needed to be present before the cell could be opened. When the cell was opened, Prison Officer Mutch radioed to the control room to call for an ambulance and then began chest compressions. Officer Glendinning placed JD in an adjoining cell and then returned to help Peter Mutch at Mr Hamilton's cell. Stephen Helsegrave, the prison officer who had heard the alarm call when conducting a patrol, went to the gatehouse to meet the ambulance and then brought the paramedics to the cell.

[49] This short but dramatic sequence of events between 11.02pm (when Mr Helsegrave checked the cell hatch) and 11.20pm (when the paramedics arrived) gave rise to a number of specific questions raised at the Inquiry. It is appropriate that I address these here:

- 1) *Was it significant that PO Helsegrave used the telephone rather than his personal radio to call for help?*
No. He thought he could relay the problem more clearly to the gatehouse (even though at that stage the cell had not been opened) by using a telephone on B Hall rather than his personal radio. This did not cause any delay.
- 2) *Should PO Mutch have brought the defibrillator from the gatehouse to the cell?*
This was a difficult decision for the officer. At the time of the call from Officer Helsegrave, Mr Mutch was alerted to a 'Code Blue', namely that a prisoner had difficulty breathing. He knew no further detail of the difficulty and did not want to slow down his arrival at the cell by carrying a defibrillator machine which might not have been required. His decision was reasonable.

- 3) *Was it significant that chest compressions were carried out with Mr Hamilton remaining on his bed?*

A question was raised about whether the compressions were less effective because Mr Hamilton was not placed on the floor first. Dr Hutcheon's opinion was that, while placing a patient on an open, hard surface was the preferred method, it was unsurprising and not significant that the prison officer had decided to try and help Mr Hamilton on the bunkbed where he was lying. This decision was unlikely to have made a difference. Dr Hutcheon said that it was very difficult to perform CPR in a non-hospital setting.

- 4) *Did PO Mutch's decision to carry out chest compressions only, without mouth to mouth resuscitation in addition, make any difference?*

Mr Mutch said in evidence that he was unable to perform mouth to mouth resuscitation effectively as part of CPR. This had been a problem for him even in training; he chose therefore to continue only with chest compressions on Mr Hamilton. Dr Hutcheon said in evidence on this point that it was unlikely to have made a difference. Dr Hutcheon emphasised that the important procedure was the regular chest compression; Mr Mutch performed compressions for over 15 minutes until the paramedics took over.

- 5) *Should PO Helsegrave have been sent back to collect the defibrillator after the cell had been opened?*

By the time it was apparent that a defibrillator may have been of some use, it was not feasible for any of the three prison officers to return to the gatehouse to collect the defibrillator. It was inappropriate for Mr Mutch to have been left on his own with the prisoner, so Katrina Glendinning remained. Officer Heslegrave could have been sent to fetch the defibrillator, but he had to choose between doing that or waiting at the gatehouse for the arrival of the ambulance. He chose the latter course. That was a reasonable decision.

- 6) *Why was a defibrillator relevant to Mr Hamilton's condition?*

This was a question addressed in Dr Hutcheon's area of expertise. As a consultant cardiologist he gave evidence about the workings of a defibrillator and its place in the treatment of cardiac events such as a myocardial infarction (heart attack). A defibrillator seeks out a heart rhythm, even when no pulse can be found. The machine works both to detect and then treat a 'shockable rhythm' by applying an electrical shock. It is far more effective than CPR such as chest compressions: Dr Hutcheon said that CPR "*buys time*".

- 7) *Would Mr Hamilton have been more likely to survive if a defibrillator was used immediately after the cell was opened at 11.04pm?*

Dr Hutcheon's Report concluded from his examination of all of the records that it was "*very likely*" that Mr Hamilton's condition was irreversible by the time chest compressions began. He said in evidence that the description by Mr Hamilton's cellmate of the frantic, agitated, behaviour from Mr Hamilton was indicative of an irreversible fatal event occurring at 11pm. A defibrillator at that point would have offered only a "*slim possibility*" of treating him successfully. Nevertheless, Dr Hutcheon's evidence was that defibrillators "*can save lives*": this was why such devices are now commonly placed in public shopping malls, leisure centres, etc. They are simple to use for those not medically trained, and operate with very clear audible instructions which start as soon as the machine is activated. They are a valuable emergency resource. This was why, for Dr Hutcheon, difficulties in the prison officers' access to a defibrillator "*to potentially treat a fatal arrhythmia*" was a concern.

[50] I concluded from the helpful evidence of Dr Hutcheon that it would have been appropriate for the prison officers to have easier access to a defibrillator in the prison hall once they had opened the cell door. Furthermore, had a defibrillator machine been more readily available for the grouping of Halls A, B and C (and the other halls within the prison similarly grouped together) some of the stressful dilemmas detailed above which were faced by the prison officers reacting to the emergency would not have arisen.

[51] The Inquiry was informed (and it was agreed in a joint minute) that, following the events of October 2014 there are now three defibrillator machines present in Dumfries Prison. One is in the gatehouse, one at a location which serves Halls A, B and C, and the third at a location which serves Halls D and E. Accordingly it would appear that, were the events which occurred on 3 October 2014 to arise today, a defibrillator machine would be more readily available in the prison halls for use by officers treating an emergency.

3. That consideration should be given by SPS to enabling a prison doctor to have appropriate access to relevant prisoner medical records when advice is being provided by the doctor in relation to a prisoner from a location other than the prison.

[52] There was conflicting evidence about the advice given by Dr Sabur after 5.30pm on 3 October 2014 when he was called by Nurse Lynsey Wood. I have detailed above the differing passages of evidence concerning whether the doctor was or was not aware of Mr Hamilton's diabetes at the time he gave advice to the nurses during that call. I was not satisfied on the balance of probabilities that Dr Sabur knew of the diabetes when giving the telephone advice. He had last treated Mr Hamilton at the prison three months earlier.

[53] The medical centre at HMP Dumfries was staffed by skilled and experienced nurses from 7.15am until 9pm. They had the benefit of a doctor providing a daily surgery for one or two hours in the mornings, with an appointment system scheduling attendances. During the twelve hours or so when nurses were on duty but the doctor was not present, there was an arrangement which had evolved: Dr Sabur could be contacted by telephone for further advice. The nurses contacted Dr Sabur on 3 October 2014 during their 5.30pm consultation with Mr Hamilton when the doctor was at his own GP surgery. They were seeking reassurance and advice.

[54] It was clear from the evidence at the Inquiry that 'prison medicine' is a developing speciality. In any random grouping of 170 adult patients there are undoubtedly numerous challenges which can emerge. In the prison setting matters are more complicated: according to the evidence of Alison MacDonald, the nursing expert,

there is likely to be a higher proportion of mental health complications within such a group. It was helpful for prison nursing staff to be able to seek advice by telephone from the prison doctor outwith the times of his scheduled visits. Without such a facility it would be more likely that the nursing staff at the prison would have to either transport a prisoner to hospital or summon an ambulance to obtain a second opinion.

[55] However, there appeared room for improvement to the arrangements by which telephone advice was sought, given the differing recollections about what was said during the call between the nurses and the GP on 3 October. Enabling the prison doctor to have access to the prisoner's medical records remotely would improve that service. It would improve the communication between medical centre staff and the doctor. It would immediately highlight to the doctor aspects of the prisoner's underlying condition, history and treatment which may be relevant to the presenting problem, but which may not be apparent to the nursing staff seeking the advice.

[56] The VISION software system, as well as recording every medical visit made by a prisoner throughout his time in all Scottish prisons, contained a patient summary.

Andrew Hamilton's patient summary highlighted at the beginning under the heading of '*Problems*' that he was '*Type 1 diabetes mellitus*'. Dr Sabur knew diabetes presented a greater risk of cardiac problems; the nurses did not. Dr Hutcheon explained in evidence that diabetes can mask symptoms and cause them to become atypical. Heart and blood pressure readings, for example, can appear normal even when a patient is undergoing more severe difficulties than such readings may suggest. If Dr Sabur was able to access information from the patient file from his own surgery when giving advice to the prison,

he would have been in a position to note the diabetes without question, and to advise appropriately.

[57] It is because of those circumstances that I recommend that, when such discussions take place, the doctor who is offsite should be able to access the relevant prisoner's medical file. There may be security and data protection implications for such a development. However, I concluded that this is a matter which would allow the prison doctor to be sure that he or she knows all of the relevant background when giving advice. It would allow nursing staff to have confidence in seeking telephone advice when they have an unusual presenting complaint. It would be far less disruptive than leaving the nurses to resort to their local accident and emergency services when they are in doubt about what further steps to take.

Conclusion

[58] Mrs Lynn Hamilton, the mother of the deceased prisoner Andrew Hamilton, was the first witness at this Fatal Accident Inquiry. She herself has been a nurse for many years and she raised a number of questions about her son's care. I wish to extend to her, and the other members of Mr Hamilton's family, my sympathies for their loss.

[59] It has been the task of this Inquiry to address a number of concerns raised by the Crown acting in the public interest in calling these proceedings. Those in lawful custody are, by definition, not at liberty independently to seek help or make decisions about their own care and treatment. It is therefore important that, when an event occurs like the untimely death of 27 year old Andrew Hamilton in prison, there is scrutiny of the

circumstances surrounding it. This Inquiry has had to shine a light on various matters: a number of reasonable precautions, recommendations, and a system defect have been identified as a result.

[60] However, it is important to point out that I have concluded that all of those who dealt with Mr Hamilton on the day of his death and who gave evidence to the Inquiry, acted in good faith and sought to provide what they believed at the time was an appropriate level of help.

- Prison Officer James Duff encouraged Mr Hamilton to seek assistance from the medical centre,
- Nurses Wood and McGowan took his readings and symptoms, gave him medication, sought further advice from the prison doctor, and later in the evening insisted that Mr Hamilton came back to the medical centre to check how he was doing,
- Dr Sabur made himself available to speak to the nurses who were seeking reassurance during the early evening consultation, though he had completed his onsite duties for that day,
- Prisoner JD showed concern for his cellmate and summoned assistance when it was clear that emergency help was needed late at night,
- Prison Officer Stephen Helsegrave responded immediately when he learned of the emergency cell call,
- Prison Officer Peter Mutch called for an ambulance and carried out immediate and sustained CPR until the paramedics arrived,
- Mr Louis Stankovic and his fellow paramedic gave Mr Hamilton all the emergency help they could to try and revive him.

[61] Andrew Hamilton died from natural causes, but it is to be hoped that lessons have been learned from the events, circumstances and systems which this Inquiry has established were relevant on 3 October 2014 at HMP Dumfries. It is also to be hoped that those implementing any changes or considering decisions made that day take due account of the full circumstances which this Determination has set out.

[62] I am grateful to the procurator fiscal depute, counsel, and the solicitors who appeared at this Inquiry for their professional preparation and conduct of this Inquiry, particularly in relation to the carefully crafted written submissions which were provided after the evidence had concluded.